

VERBATIM PROCEEDINGS

CONNECTICUT HEALTH INSURANCE EXCHANGE

HEALTH PLAN BENEFITS AND QUALIFICATIONS
ADVISORY COMMITTEE MEETING

JUNE 8, 2012

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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RE: CONNECTICUT HEALTH INSURANCE EXCHANGE
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1 . . .Verbatim Proceedings of a meeting
2 before the Connecticut Health Insurance Exchange, Health
3 Plan Benefits and Qualifications Advisory Committee held
4 on June 8, 2012 at 10:30 a.m. at the Legislative Office
5 Building, 300 Capitol Avenue, Hartford, Connecticut. . .
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7

8 CHAIRPERSON ANNE MELISSA DOWLING: Thank
9 you Committee members for joining us, and thank you
10 everybody in the audience for being here as well. Just -
11 - and I'm, for those of you I haven't met, Anne Melissa
12 Dowling, one of the co-chairs. And Mark Espinosa is the
13 other co-chair of our Committee.

14 A couple of opening remarks and then we'll
15 turn it over to the team who did this enormous amount of
16 work for us in a very short period of time, and because
17 we have an earlier meeting date. I have a couple of
18 questions, but first I want to thank you for all the
19 materials that are presented to us. And they're quite
20 comprehensive and I know we would like to have them
21 earlier than we did, but I wanted -- before I ask the
22 questions I want to ask, I just want to turn this over to
23 Mary Ellen for a moment who is just -- who explained to
24 me why the data came when it did. And I think it's quite

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1 interesting, and it sort of illustrates the way the
2 process is so dynamic. So if you wouldn't mind. Thanks.

3 MS. MARY ELLEN BREault: Sure. Just to
4 let you know the National Association of Insurance
5 Commissioners has been having on-going conversations with
6 staff from HHS and one of the issues is with regard to
7 the essential health benefits package and the picks of
8 the essential, the plans, the benchmark plans. And HHS
9 has stated that they are looking at their HIO system,
10 that's the name of the system where they collect this
11 data, and that they were going to hold states to their
12 picks for these plans. But we had done a survey, as most
13 other states did, just to make sure that we were in sync
14 with those plans. The original list that they published
15 in December was just an example. It was never intended to
16 be the list of benchmark plans. And so they told us that
17 they would be publishing the final list in July, but
18 because states had concerns about the accuracy of the
19 data on the HIO system they were going to try to get it
20 to the states a little ahead of time and sometime in May.

21 Well, we just got that. I received that on
22 Tuesday last week. And we sent -- we wanted to verify
23 with the plans in question. And it was a little different
24 than the December one. So we contacted the individual

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1 carriers and sent back the numbers from the HIO system
2 and asked them to verify that the data they had provided
3 to us was correct or if not to update it. And we only
4 gave them until last Friday to update it. So, even though
5 we probably should have sent out something letting you
6 know what was happening it was such a short timeframe and
7 the amount of work that the staff especially once they
8 got the data put in to compile this was enormous that it
9 just, you know, it definitely slipped my mind. So we
10 apologize for that.

11 But basically that is why some of the
12 plans have changed. Now, Aetna is one of those plans and
13 so the data that we -- and a few of the carriers had to
14 make some modifications to the original data they sent to
15 us. So the team was really scrambling to put all of this
16 together for you. So I just wanted to at least let you
17 know that. And that was the reason that you couldn't
18 really get it much sooner than you did.

19 CHAIRPERSON DOWLING: Thank you very much.
20 It remains dynamic process. Two things for our meeting
21 today, one is we have an enormous amount of data but it's
22 appropriate, we asked for it. So, we have to sort of
23 live with that and thank you. I know there are probably
24 a number of questions, but let me just set a goal for the

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1 meeting and then I have a question about the data that's
2 just a straightforward one.

3 I think because we have such a compressed
4 period of time between now and July to get answers and
5 decisions made do you think we can use the next two hours
6 to actually winnow down by the end of today to a couple
7 of plans? And if you do think we can do that, please
8 give us the outline for how we might get through that
9 today, if you can guide us through that, because I think
10 what we'd like to know is what we have between us and
11 July and how we can get to the end point.

12 Having said that, and because there was so
13 much data to get through and so many of you were great at
14 getting through piles of this which was -- it was
15 fascinating, but because we had to do it in a compressed
16 period of time we might have come to conclusions that
17 were erroneous or not. So some have read this and thought
18 that it looks as if the conclusion subtly is directing us
19 towards selecting a federal plan. And I just want to ask
20 you if that wasn't my understanding when we started this
21 a couple of meetings ago, and so just to frame the
22 meeting, is that -- I know I'm asking two big questions,
23 but is that accurate?

24 MR. ROBERT CAREY: So, no, that's not the

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1 intent nor the direction that I hoped we were sending the
2 Committee. Our role as staff and consultants is to
3 provide you with the facts and to opine on those facts
4 when appropriate. We didn't feel it was appropriate, at
5 this stage of the game, to make a recommendation. We
6 think that that's what this is all about is to go through
7 the information and to make a recommendation. So,
8 unfortunately, the way that we wrote the memos some have
9 interpreted that we were, in fact, guiding people toward
10 the federal plans.

11 I think when we go through the discussion
12 today you'll see that that's actually the opposite of
13 what we were trying to do. And what we were trying to do
14 is to point out areas in which there are meaningful
15 differences between the, between all the plans or across
16 all of the plans. So are there differences within the
17 small group plans that are different than the state
18 employee's plan, that are different than the federal
19 employee's plan? And so that's what we're trying to do.
20 And we hope that at the end of today's discussion, the
21 Committee will feel comfortable either winnowing it down,
22 or eliminating some options would be staff's preference,
23 because just speaking for the folks who have been working
24 on this it's a lot of -- you know, the evidence of

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1 coverage for each plan is a big evidence document. And we
2 want to make sure that we give you the right information
3 in as summarized a form as possible. We don't want to
4 send out ten EOC's for you to go through that. We think
5 that that's our role.

6 And having said that, there are actually
7 some corrections we need to make to that more detailed
8 list of services that are covered. And we will send out a
9 corrected memo. We don't think it's significantly
10 material. But there are some areas where we said, no, it
11 wasn't covered and, yes, in fact it is covered. And so
12 we'll highlight those. We won't make you play a game of
13 comparison to figure it out. We'll highlight those areas
14 where the original document said one thing and the follow
15 up document will say another. So, that's just sort of a
16 point that I wanted to make prior to.

17 Again, I don't think that we had erred.
18 It is material to the discussion. Although we certainly
19 could point them out right now if you'd like. But I think
20 for the sake of moving the meeting along it probably
21 makes sense to just go through the presentation. We think
22 that at the end we'll be able to hopefully throw out some
23 options that are currently on the table.

24 CHAIRPERSON MARK ESPINOSA: If I could, I

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1 just want to make sure I'm understanding the role today.
2 Well, the goal for the Committee today then, Bob, is it a
3 definitive -- coming to a conclusion toward the end of
4 this meeting is one thing, but is it a finality that's
5 being expected or do we reconvene certainly prior to July
6 -- our think our next date was July 11th tentatively
7 scheduled. So, my suggestion, recommendation would be,
8 and even if it was via a conference call, is it too
9 ambitious? For instance, I personally have not had
10 enough time to -- and thankfully the Celtics got blown
11 out last night so I could read a little more last night
12 on this because I gave up watching the game. But, in any
13 event, so my question is that. Are we walking out of here
14 today -- and then also my other comment is I'm not
15 leaving in protest. I have to be out of here by 12:10, so
16 it's not a sign of protest. So that was my comment,
17 question, suggestion.

18 MR. CAREY: Yes, given that you just
19 received the data a couple of days ago we are not under
20 the expectation that people, a, had the chance to go
21 through all of it. And, b, feel comfortable making a
22 final decision. So, but we do think, hopefully, that you
23 will feel at least comfortable tossing out some of the
24 options so we can then zero in on those that are, that

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1 the Committee feels are among those that would be the
2 best option for the state.

3 Another point of clarification to Mary
4 Ellen's point is, you know, the feds are constantly
5 issuing guidance and rules and regulations. And just on
6 June 1st they issued another notice of proposed rule
7 making about the essential health benefits package, about
8 the qualified health plans. It was really directed
9 toward the carriers so that they could provide
10 information to the feds so that the feds will have the
11 necessary information as we are doing to make the
12 decision about what's the essential health benefits
13 package in those states primarily in which the feds are
14 going to be running these exchanges. So that came out
15 June 1st. We've had a chance to go through it. I don't
16 think it -- it's more a data collection rule than it is
17 sort of a definitive rule about what is the essential
18 health benefits package.

19 So to answer your question, no, we don't
20 expect the Committee to come to a final decision today.
21 And, yes, it probably makes sense, in the interim between
22 now and July 11th, where we have a con call or a webinar
23 or something where the Committee can get together.

24 CHAIRPERSON DOWLING: So with that, let me

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1 just do the housekeeping of minute approval and then
2 we'll turn it over to you. You've all received the
3 minutes from our last meeting. And we need to just
4 approve and vote on those today or not. Are there any
5 edits to the minutes? Then could I just --

6 MR. STEPHEN FRAYNE: -- just one edit.
7 It's not significant. I work for the Hospital
8 Association, not Hartford Healthcare. I would be happy to
9 work for Hartford Healthcare, but I currently do not.

10 CHAIRPERSON DOWLING: Thank you. All
11 right, so could I just hear a motion to approve the
12 minutes?

13 VOICES: So moved.

14 CHAIRPERSON DOWLING: I'll take one of
15 those as a second. Thank you. All in favor?

16 ALL VOICES: Aye.

17 CHAIRPERSON DOWLING: Any opposed? Thank
18 you.

19 Any overarching, framing questions? Yes,
20 Jennifer.

21 MS. JENNIFER JAFF: I just want to say
22 since I'm one of the people who asked for a lot of this
23 additional information I am thoroughly amazed at the
24 amount of work that you were able to do in such a short

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1 period of time. And I just wanted to thank you very much
2 for making our job so much easier by doing all of the
3 work that you did. So, thank you very much.

4 CHAIRPERSON DOWLING: I'm just asking for
5 any other questions before we turn it over to the team.
6 Thank you.

7 MS. NELLIE O'GARA: Okay. So, just to
8 level set again, you've got a lot of information in front
9 of you. It is the opportunity now to clarify and to
10 address any additional questions. Bob is going to take
11 us through what we've called an EHB discussion road map
12 that pretty much goes through where we left off last week
13 with addressing some of the questions you had. And then
14 we are hoping to lead through that to get to the point,
15 again, where we might be able to winnow down to a couple
16 of the most feasible options and then focus our attention
17 on those.

18 So, Bob, if you want to start with that
19 discussion.

20 MR. CAREY: Sure. So, just to set the
21 process up this is, we're here at the Advisory Committee
22 meeting working through the essential health benefits
23 options that are available to the states. This Advisory
24 Committee will make a recommendation we hope in time for

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1 the July Exchange Board meeting at which time the
2 Exchange Board will either move to make a recommendation
3 to the state or perhaps delay that until August.

4 I will say that in conversations we were
5 in D.C. a couple of weeks ago. We had what they call a
6 gate review. So, all of the states have to go through, or
7 the states that are actively engaged in exchanges have to
8 go through a review process with the feds to show the
9 feds the progress that we're making. At that meeting when
10 we walked through our timeline for making a decision
11 about the essential health benefits package and had a
12 September 2012 date the response was, well, we said third
13 quarter of 2012. We didn't say September of 2012 which
14 made me think, well, it would be nice to get a hard date
15 from the federal government. But, it just made it more
16 critical for us to move through and make a decision in a
17 timely fashion.

18 So, we're hoping that by July people will
19 feel comfortable with, yes, this is the package and that
20 we can make a recommendation up to the Exchange Board and
21 the Exchange Board, many of whom sit on these committees,
22 will feel comfortable moving that recommendation to the
23 state. So that's where we stand today and the roadmap
24 going forward.

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1 It's also critical to make these
2 decisions, I should say, because the carriers have to
3 have time to react to the decisions about what's included
4 in an essential health benefits package. And we'll have
5 to build plans around that they cover all of those
6 essential health benefits. So just a couple of points
7 there.

8 So we wanted to go through -- first let me
9 back up, an overview of the decision making process, the
10 clarification of essential health benefits requirements.
11 There were some questions that we had, that the Committee
12 had with regard to some areas of the essential health
13 benefits package, state mandates in the essential health
14 benefits how they play into this discussion. We -- then
15 we'll move into sort of guiding principles and some
16 decision criteria. We have some suggestions about the
17 criteria that you might use to try to narrow down your
18 decision. Then go through those benchmark options and
19 next steps.

20 So the first question really came around
21 prescription drugs and, in particular, the reality that
22 in Connecticut most plans, including the state employees'
23 health plan, sells or packages prescription drugs not
24 within the base product but as what they call a rider. So

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1 you can purchase prescription drug coverage separately
2 from the medical benefits that are provided under the
3 health plan.

4 CCIIO, the Center for Consumer Information
5 and Insurance Oversight, which is the federal agency
6 that's sort of overseeing exchanges and lots of the
7 implementation of the ACA, their view of riders is that
8 with regard to the essential health benefits package that
9 you can't couple a plan with a rider. So if a health
10 plan, and as we'll go through many of our options with
11 regard to the health plan piece sell the drug rider,
12 don't include the drugs as part of the base package
13 that's sold as a rider, so CCIIO was saying you can't
14 take that rider and couple it with that base plan. You
15 have to go to another benchmark plan option and use that
16 benchmark's plan option as the prescription drug benefit
17 for your essential health benefits package.

18 That's true across all the statutorily
19 required categories. So we'll talk also about pediatric
20 dental and pediatric vision, which commonly or not part
21 of a health benefit that they're usually sold separately
22 in terms of a dental benefit, in particular. The state,
23 states can't go and just pick any dental benefit. There
24 are certain restrictions that the feds are using.

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1 But with regard to prescription drugs, so
2 the issue is of the benchmark plan options really only
3 three have prescription drugs as part of its base
4 package. So the issue is if you all, the state
5 eventually, selects a benchmark plan that does not
6 include prescription drugs you'll have to supplement that
7 plan with either the federal employee's health plan's
8 prescription drug benefit or the Oxford PPO prescription
9 drug benefit. You don't have to pick Oxford or federal
10 employees for the base plan. You can pick another base
11 plan, but you'd have to couple it with either Oxford or
12 the federal employee's plan.

13 MR. ROBERT MCLEAN: Bob, just a quick
14 question. As I'm looking at the table that has kind of
15 all the details on page nine is where it has the
16 prescription drugs, if I'm reading it correctly, and it
17 does not indicate that Oxford is different than the
18 others. So I'm just -- is that an error?

19 MR. CAREY: It's an error.

20 DR. MCLEAN: Okay.

21 MR. CAREY: You know, if you go and pull
22 the file at the insurance department it says rider on the
23 top, but then when you ask the health plan can I buy this
24 plan, this Oxford PPO without drugs, they say no. We

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1 don't sell it without drugs. So it's actually part of
2 their base plan, but -- so technically it looks like it's
3 a rider, but, no, that's incorrect the information that's
4 there.

5 DR. MCLEAN: So that should be a yes in
6 that category.

7 MR. CAREY: That should be a yes, yes,
8 sir.

9 MR. ROBERT TESSIER: Bob, I don't want to
10 belabor an issue that you've explained well, but I'm
11 wondering if is our experience in Connecticut where
12 prescription drugs are a rider to a health plan different
13 from the norm nationally? I didn't -- I see Mary Ellen
14 shaking her head no.

15 MR. CAREY: Not in the small group market,
16 but I will say the state employee plan it struck me as
17 somewhat of an anomaly that they would sell a benefit or
18 offer a benefit to employees that doesn't include
19 prescription drugs.

20 MR. TESSIER: They do because -- they do
21 it because they contract with a different provider, a
22 different vendor for that and they get a better deal than
23 they can through the carrier frankly. I think.

24 MR. CAREY: So I've worked for years

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1 helping to run the Massachusetts state employee's health
2 plan and we carved out prescription drugs, but you
3 couldn't buy, you couldn't enroll in coverage without --
4 it wasn't an option to exclude prescription drugs and
5 that's, I guess, my understanding of the way that the
6 state does it. Because if it's only a separate vendor
7 it's not as if it's a rider, it's simply you just
8 contract with, you know, a PDM to handle the prescription
9 drug benefit. Or lots of times you'll contract with a
10 mental health or a behavioral health vendor who handles
11 the mental health benefit. But the package, the benefit
12 that's offered to the employee it's an option whether to
13 have mental health or prescription drugs. So I was a
14 little confused as to why it's considered a rider.

15 MR. TESSIER: I'm not able to address
16 that, but I will say I do know for the state employee
17 plan it's a separate vendor. It's CVS care markets not
18 any of the three health, medical plans that are offered.
19 It's not Anthem, it's not United, and it's not, what, the
20 third one I can't recall. So, it is -- I'm sorry.

21 MR. CAREY: So it's a -- I guess it's a
22 separate policy here. Anyway. So, that was the only issue
23 that I thought that sort of where -- with regard to small
24 groups in general in many states, although not my state

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1 of Massachusetts where you have to have prescription drug
2 coverage, in many states they do offer this as a sort of,
3 you can buy the rider.

4 MR. CAREY: Okay. So that's the drug
5 benefit issue. Again, CCIIO was also telling us we're
6 going to give you additional information about the
7 formulary and what that needs to look like with regard to
8 these essential health benefits. But stay tuned. We're
9 not yet ready to tell you. So, again, we're waiting for
10 additional federal guidance on that.

11 There was a question with regard to
12 specialty drugs. These are typically high cost drugs,
13 injectables, or infused drugs that it's very, sort of
14 limited conditions for which the drugs apply. And we
15 just wanted to make sure that the specialty drugs were
16 covered under the really two options with regard to drug
17 benefits that we looked at. This does not get into
18 what's the cost sharing, which is a huge issue for
19 specialty drugs because in some plans they put it into a
20 separate tier with co-insurance. And 25 percent co-
21 insurance on a drug that costs \$2,000 a month is a lot of
22 money for the consumer. So this simply gets at does the
23 formulary include cover a specialty drug and the ones
24 that we looked at do include.

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1 DR. MCLEAN: Does it differentiate based
2 upon the gold, silver, bronze, whatever that that co-pay
3 presumably?

4 MR. CAREY: Yes, that's exactly right. So
5 the co-pay would be affected or the tier level, the tin
6 level would affect the cost sharing down to these types
7 of services. But the fact that it is a covered benefit
8 wouldn't be affected by what tier it was in.

9 Okay. There were three other issues that
10 we identified as typically not part of a medical benefit
11 anywhere, Connecticut or any place in the country. It's
12 sort of the base package. Those were habilitative care as
13 opposed to rehabilitative care, a pediatric dental and
14 pediatric vision. The bulletin that the feds issued in
15 December and then supplemented with an FAQ document in
16 February goes into a little bit more detail about these
17 three issues. If the Committee is interested I would
18 point you to that bulletin which spells out the approach
19 that the feds think they'll take. Again, it's a bulletin.
20 It's not a rule. So until it's a final rule we won't be
21 certain what the approach will be.

22 I will say with regard to the rider issue
23 I do think the feds are rethinking whether or not states
24 could couple a benchmark, a base benchmark plan with the

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1 drug rider that's sold with it. But they've not --they're
2 taking that under advisement, I guess.

3 So rehabilitative and habilitative care
4 are a required category within the Affordable Care Act.
5 The bulletin acknowledges that there is no generally
6 accepted definition of habilitative services. And then
7 it goes on to suggest definitions, one, focused on
8 learning new skills and functions as opposed to
9 relearning or rehabilitating your ability to do certain
10 things. And then the concept of keeping or maintaining
11 functions for what they describe as the maximum reduction
12 of physical and mental disability and restoration of a
13 recipient to his best possible functional level, which is
14 I guess the Medicaid definition of habilitative care.
15 Again, habilitative care, even in the Medicaid program,
16 is an optional category of care that states could offer
17 to their Medicaid beneficiaries. Not many states do. I
18 don't know what the Connecticut policy is on that.

19 So then the fed threw out two options. In
20 their current thinking, which we were actually quite
21 surprised at, is that the carriers will decide which
22 option they take with regard to offering habilitative
23 services. The first option is that they offer it on par
24 with the rehabilitative services. So you'll see speech

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1 therapy, occupational therapy, physical therapy is
2 covered, typically, by carriers and they'll limit the
3 number of visits that someone can get for certain
4 rehabilitative services. And so one option is for
5 carriers to cover habilitative services at the same level
6 that they cover rehabilitative services.

7 The other option is for the plan to decide
8 which habilitative services to cover and then report that
9 coverage to HHS. So those are the two options currently
10 on the table. Again, we think they may be revisiting
11 these so that it may be the -- each state would decide
12 rather than the plans decide which -- how they're going
13 to cover habilitative services.

14 DR. MCLEAN: So a question on that, so, I
15 mean it's a requirement that they have these habilitative
16 plans. It sounds like we're not determining or we can't
17 determine what's involved except to say to a plan you
18 have to have it. And after the fact they decide one of
19 those two options? Or we should help direct whichever
20 plan we pick that this is what you need to have.

21 MR. CAREY: Well, the current HHS guidance
22 is that the plans will report how they're going to cover
23 habilitative services. We could recommend that HHS not
24 provide that permissive level of decision making and that

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1 should be part of the essential health benefits
2 requirements at the state level. But under the current
3 guidance that's the way the feds are approaching this.

4 DR. MCLEAN: So there is no real way to
5 compare the plans on this.

6 MR. CAREY: No, it's not covered.

7 DR. MCLEAN: Right, okay.

8 MR. CAREY: You could -- we will and you
9 can compare how rehabilitative services are covered and
10 then that is how we think the extension will be or what
11 the extension will look like.

12 DR. MCLEAN: When you say it's not covered
13 you mean --

14 MR. CAREY: -- it's not part of their
15 current package of benefits.

16 DR. MCLEAN: So we don't have to include
17 it.

18 MR. CAREY: No, we have to include it.

19 DR. MCLEAN: Okay.

20 MR. CAREY: In 2014.

21 DR. MCLEAN: Got it.

22 MR. CAREY: But what I'm saying is that
23 when we look at benchmark plan options you're not going
24 to see a category --

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1 DR. MCLEAN: -- got it.

2 MR. CAREY: That says habilitative care.

3 DR. MCLEAN: Okay.

4 MR. CAREY: Okay. Then with regard to
5 pediatric dental and pediatric vision they're intended
6 options are the largest federal dental plan or the dental
7 benefits in the state's CHIP program. So we will have to
8 make a decision about how the requirements with regard to
9 pediatric dental coverage within a qualified health plan
10 and then also pediatric vision that point to the largest
11 federal vision plan. I think the information we provided
12 to the Committee includes that level of detail about
13 those two options.

14 So those will be really sort of
15 supplementary to what the base plan looks like. And we'll
16 have to make some recommendations going forward with
17 regard to how we treat these, in particular these three
18 categories of care.

19 So, now moving onto state mandated
20 benefits and the essential health information we sent
21 you, summarizes each of the state mandates. It goes into
22 pretty good detail about what those mandates encompass.
23 And then we tried to classify them among the ten
24 categories of care. This was actually more difficult than

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1 I think we first assumed because, you know, certain
2 mandates can be classified in a number of different
3 categories of care and you'll see that we took our best
4 educated guess at which of the categories of care a
5 mandate might fall under.

6 That doesn't mean that every mandate, just
7 because you can fit it under a category of care, would in
8 some future date be included in the essential health
9 benefits package if the feds ever decide that they're
10 going to set the essential health benefits package. What
11 we tried to do is simply bucket them into the various
12 categories of care so that the Committee could see what
13 that looked like. And then we also provided additional
14 details about each of the mandates.

15 Here is a critical point. Even if the
16 Committee and the state finally decided that they were
17 going to select an essential health benefits package that
18 didn't include one or two or three of the mandates. So,
19 for example, we'll go into detail on this with regard
20 with the federal plan. The federal plan does not include
21 certain of the state mandates. If the Committee chose,
22 and the state chose the federal employee health benefit
23 plan as its benchmark plan that wouldn't mean that the
24 mandates would go away. The mandates are the mandates.

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1 And unless there is an act of the legislature and the
2 Governor to do away with a mandate that's the only time
3 in which you could sell a policy because the division,
4 the Department of Insurance would not license a plan to
5 be sold in the State of Connecticut's individual or small
6 group market if it doesn't include all of the state
7 mandates.

8 So, that's just a clarification. The
9 issue is if you chose a benchmark plan that does not
10 include a mandate, so the federal employee health benefit
11 plan, let's be specific about which ones. If you chose
12 that plan the state would have to pick up the cost of the
13 state mandate. So we have three examples, in vitro
14 fertilization, the mandate around Lyme disease treatment,
15 and autism spectrum disorder. We don't think, again,
16 reading through all of the details of the federal plan
17 that the federal plan includes these three, covers these
18 three mandates. There would have to some calculation of
19 well how much does it cost to provide Lyme disease
20 treatment and how much does it cost to provide autism
21 spectrum disorder? And then you'd have to quantify that
22 and the state would have to pay -- for every person that
23 purchased a health plan through the exchange the state
24 would have to pay that marginal difference between the

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1 premium without these mandates and the premium with these
2 mandates. So that's the purpose of torturing you with
3 this discussion around essential health benefits and
4 state mandates because there is a fiscal impact
5 potentially to the state as well as sort of a policy
6 impact with regard to how the state wants to move
7 forward.

8 DR. MCLEAN: A question on that, I don't
9 know off hand the details of those state mandates. I mean
10 do we have them handy? What exactly does that involve?

11 MR. CAREY: Yes, it's in the packet.

12 DR. MCLEAN: Is it? Okay. It's page
13 what?

14 MS. O'GARA: Yes, Doctor, if you look at
15 Exhibit No. 1 and the entry is 22, just as an example
16 Lyme disease, it goes across.

17 MR. CAREY: And then there is the actual
18 lift from the statute we provided you as well so that
19 gets into the -- that's the actual verbiage from 700c.

20 MS. MARGHERITA GIULIANO: I have a
21 question not being an insurance guru, how does ERISA
22 impact all of this going forward?

23 MR. CAREY: That's a good question. So
24 ERISA is a federal essential preemption of state

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1 mandates. So, health plans that are self-funded largely
2 fall outside of the regulation of insurance by the states
3 and it sort of moves up to a federal level. So most large
4 employers, like the state employee health plan, is self-
5 funded. They don't have to cover these state mandates.
6 So, ERISA plans are sort of exempt from the, this
7 discussion and these mandates.

8 CHAIRPERSON ESPINOSA: If I may, just a
9 good point because I'm still questioning in my world
10 relative to ERISA and I know you're familiar with, you've
11 dealt with the Mass. connector and the unions in
12 Massachusetts. So, I'm still concerned and wondering,
13 you know, with respect to Tath Hartley law and my fund we
14 have 20,000 employees in the State of Connecticut. We're
15 not state employees, but we're governed -- we have
16 exemptions right now that we file for that we're
17 protected from until. So, I've been asking this question
18 a lot in terms of where, you know, this is from a selfish
19 standpoint I want to know, you know, because I've got a
20 major employer in the State of Connecticut getting ready
21 to start bargaining with us at the end of this year for a
22 new contract. And they're sitting on pins and needles
23 wondering. So I'm just wondering, like where do you
24 think that's going in terms of in the Tath Hartley world

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1 particularly with the predominance of part time employees
2 that I represent that are covered under a plan right now.

3 The service employees union is another one I can think
4 of in Connecticut that has a high preponderance of part
5 timers. So, we're sort of protected at this point, but
6 going forward how do you -- have you had any experience
7 in terms of bargaining arrangements? And I'm not sure if
8 I'm asking the right question here.

9 MR. CAREY: No, no. I understand and,
10 yes, I have some experience with Tath Hartley's and, in
11 particular, the food and commercial worker's union which
12 has, offers a limited benefit, but was offering sort of a
13 mini-med to their part time employees. So most part time
14 employees aren't offered anything. The union fund with
15 management was offering part time employees a mini-med.
16 It had an annual max. You know, it didn't cover beyond a
17 certain amount. Well, those are going to go away unless
18 you get an exemption for those plans. So there were
19 certain provisions of the law that do apply to ERISA.
20 This discussion of EHB and the comprehensiveness of the
21 package only applies to the individual and small group
22 market. It does not apply to self-funded plans or the
23 large group market actually.

24 So I don't know if I answered your

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1 question. But there are certain provisions of the law
2 that do apply to all insurance whether it's self-funded
3 or fully insured. There are other provisions of the law
4 that only apply to fully insured business.

5 MS. JAFF: Two things, first of all, a
6 non-federal governmental plan is exempt from ERISA,
7 right, so the state employee plan is exempt from ERISA?

8 MR. CAREY: Yes, the state employee is
9 exempt from ERISA, correct.

10 MS. JAFF: And also isn't it true, and I
11 could be wrong about this, but I thought that the state
12 employee plan in Connecticut, even though it's self-
13 funded, has agreed to cover all of the mandates.

14 MR. CAREY: Correct. So, in the second
15 bullet here, so by statute the state employee's plan
16 don't, the mandates don't apply to the state employee's
17 plan. But by bargaining or by agreement the state
18 employee's plans do, in fact, cover all of the state
19 mandates. It's not a statutory requirement. It's a policy
20 decision made by the administrator and the union, the
21 group that makes up the Commission of the state employee
22 plan.

23 DR. MCLEAN: Do you know, does current
24 Medicaid cover the state mandates?

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1 MR. CAREY: I don't believe so. I think
2 probably some of the mandates they probably cover, but
3 they're not required to cover the state mandates.

4 DR. MCLEAN: I mean having just looked
5 through them really quickly I'm not an -- so I can't
6 quote what the costs would be of IBF, but as a
7 rheumatologist and being somewhat familiar with the Lyme
8 disease law, which I don't think has changed in a number
9 of years going back like ten years, the amount of extra
10 treatment that is kind of allowed is not open ended. So,
11 I have no idea how insurance companies would kind of
12 expense that out, but that's I doubt a huge number. By
13 requiring what it does it actually, I think, brought the
14 numbers way down. So I don't know what that cost out,
15 but I don't think that's a huge ticket item necessarily.
16 The other two I have no idea.

17 MR. CAREY: Yes, I know that IBS, in
18 particular, has been identified as a material effect on
19 premiums. Now whether that's two percent, or one
20 percent, or three percent I don't know, but I do know in
21 those states where there is an IBF mandate that the
22 carriers indicate that there is a material effect on the
23 premium.

24 MS. MARY FOX: Bob, another point of

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1 clarification, if we go to the EHB federal mandated
2 requirements now back to like habilitative services, I
3 could see that they may overlap with some of the autism
4 stuff here. So how do we sort through -- are the feds
5 going to pay for the things that we just talked about in
6 terms of the habilitative services, but we would have to
7 pay for, the state would have to pay for our own
8 mandates?

9 MR. CAREY: Yes. So, the category of care,
10 rehabilitative and habilitative services, that's sort of
11 in essence a new mandate, it's sort of a federal mandate
12 now that the feds are saying all of the qualified health
13 plans have to cover habilitative services. So, for people
14 who are eligible for subsidies through the exchange the
15 total premium would include habilitative services and the
16 members who share the premium would be, in essence,
17 covered by that federal share for the habilitative
18 services.

19 Now, just remember these plans are not
20 just exchange plans. So, people who aren't getting a
21 subsidy and people who are just purchasing on their own
22 in the individual and small group market will also have
23 to purchase policies that cover all of these additional
24 services that currently aren't covered.

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1 So now the benchmark approach, so you'll
2 see we have listed here the ten, sort of ten, the
3 standard and basic are the same benefit, ten benchmark
4 plan options. A couple of notes, one Aetna POS is in
5 bold not because I love Aetna, but because it's the
6 largest small group plan amongst the three largest. So,
7 that's -- if this Committee and this state doesn't make a
8 decision about which benchmark plan to chose that would
9 be the benchmark plan because the feds have said we'll
10 chose for you and it will be the largest of the three
11 small group plan options.

12 The asterisk next to Connecticare HMO is
13 because we think it's the largest. Some of the data
14 suggests that it is the largest HMO. Other data suggests
15 that Aetna has the largest HMO membership. So, again,
16 it's sort of, you know, it's a moving target to a certain
17 extent. We don't believe, however, that the package of
18 benefits in Connecticare's HMO is materially different
19 from the package of benefits in Aetna's HMO. Again, cost
20 sharing aside just what's covered is comparable, as
21 you'll see, across all of the health plans sold in the
22 Connecticut marketplace.

23 MS. O'GARA: So, we stop just a minute. Is
24 everybody on the same page with that? Do you see the --

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1 and we're looking at -- are we looking at the exhibit
2 yet? Okay.

3 MR. TESSIER: Thank you. Bob, let me
4 preface this quick request with a comment to say I share
5 Jennifer's appreciation for the enormous amount of work
6 that went into for the whole team to pulling all of this
7 data together. And I preface it because I'm about to
8 make a small request that I hope is easily manageable.
9 And maybe I'm the only one who may find this of interest,
10 but I'm curious if it's possible for us, for the ten
11 benchmark plans, to get approximate round enrollment
12 numbers for the time period that they were selected for.
13 Because I'm just curious to get a sense of the relative,
14 as we look at the difference among the plans or between
15 the plans, it would be interesting to know whether volume
16 of enrollment is a significant issue, the differences.

17 MR. CAREY: We actually can do that for
18 you. We can't, I don't think, get the federal employee
19 plan enrollment certainly not for the State of
20 Connecticut. Maybe we could get it nationally, but that
21 almost doesn't -- but, yes, we can get what the estimated
22 enrollment is. We have that already so we'll pull that
23 together for the Committee.

24 So these are, as of right now again, you

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1 know, the feds are changing their mind as we speak, the
2 ten benchmark plan options that we'll be walking through.

3 We wanted to sort of remind the Committee
4 and also offer some additional criteria that they might
5 use with regard to how you begin to winnow down your
6 choices. These are the guiding principles sort of in
7 bulleted form that we discussed at the last meeting and
8 at the first meeting. So, that's sort of one point or a
9 few data points to consider in terms of the benchmark
10 plan option.

11 And then we offer a couple of others, one
12 we think it doesn't winnow down your choices because the
13 packages are very comprehensive. So, you know, No. 1 you
14 could put a checkmark next to all the plans in terms of
15 if offering a comprehensive coverage. But the two others
16 we think are important one is that it aligns with the
17 current Connecticut marketplace to the greatest extent
18 possible. Again, with the addition of some services, but
19 we thought that was sort of a key criteria for the
20 Committee to consider.

21 And then the third point is that it
22 minimizes any potential fiscal impact to the state. And
23 so those were our suggestions. We are sort of open to
24 folks who want to disagree or remove any of them. We

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1 don't think we need to vote on this, but we just wanted
2 it for discussion purposes.

3 MS. JAFF: To go back to the previous
4 screen, the first point was affordability. Is there --
5 can we get an average premium price for each of the
6 benchmarks? I think it's on healthcare.gov, no?

7 MR. CAREY: Well, you can get an average -
8 - you can get the base premium for these plans, but they
9 won't include all of the benefits that are required. So
10 you can get them as they currently exist, yes. We should
11 be able to pull that for the -- well, I guess we could
12 get it for the state. Yes, we could get it, I guess, for
13 all of them because you can go to the federal website and
14 get the feds premiums for their plans as well. So we
15 could do that.

16 MS. JAFF: I think that would be helpful.

17 MR. CAREY: I will caution, it will be
18 somewhat of an apples to watermelons conversation because
19 the small group plan really depends on the makeup of the
20 group. The state employees plan we know what the premiums
21 are, but it's based on the makeup of that group and the
22 federal plan is based on the makeup of that group. So,
23 just a word of caution when looking at them and saying,
24 oh, that one costs this and that one costs that is a lot

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1 -- there is -- translating those across the plans is not
2 -- you can't do it. You can't do that, so just a word of
3 caution there.

4 MS. JAFF: Do you have another suggestion
5 for how we might gauge affordability?

6 MS. BREULT: Well, I think in general
7 terms when, you know, once we start going through the
8 charts you're going to see that there really is very
9 little difference in the categories of coverage. And
10 that's really what we're talking about for the essential
11 health benefits. When we actually, you know -- once we
12 chose the package and then once we have to deal with the
13 specific plan designs down the line and the cost sharing
14 I think that's where all of that will come into play.
15 Because, you know, in addition to just the makeup of the
16 groups every carrier has different negotiated rates with
17 the various providers. So all of that comes into play,
18 and we're really not talking about the Aetna plan. We're
19 just talking about the services that are currently
20 covered under Aetna for our purposes, so I think that's
21 important to keep in mind.

22 DR. MCLEAN: Just a question, I'm not
23 certain if I missed something, but you mentioned ten
24 benchmark plans, and then the table only has seven. So

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1 are you already kind of editing down some?

2 MR. CAREY: Yes, we combined --

3 DR. MCLEAN: -- okay.

4 MR. CAREY: I think we combined the state
5 employee plans down to one because they all cover the
6 same services it's just different cost sharing.

7 DR. MCLEAN: Okay.

8 MR. CAREY: Did we combine -- and we
9 combined Blue Cross Basic and Blue Cross Standard federal
10 plan because the difference is in cost sharing not in
11 services covered. So that saves us a little time.

12 MS. DEIDRE HARDICK: And I just wanted to
13 echo Jennifer's concerns around the whole affordability
14 factor. I mean we know studies have shown they're already
15 predicting how much this is going to be costing
16 consumers. So we want to make sure as we look through
17 these plans any information we can have to sort of
18 predict the affordability and try and find the most
19 affordable to consumers and feasible for health plans to
20 try and package and put all of this information and
21 create plan designs to fit all of this.

22 DR. MCLEAN: Along those lines and this
23 just occurred to me because things like some of the state
24 mandates, especially the IBF, which is not covered in the

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1 federal plans, as I remember, is probably a huge nut. Can
2 state mandates be added as a rider? You know you kind of
3 pick everything else and then --

4 MR. CAREY: -- no, well, the issue is that
5 carriers can't sell policies in the State of Connecticut
6 that don't include the state mandates. So, your shelf
7 would have plans with mandates. The issue really is who
8 pays? Is it baked into the premium or is it carved out
9 for those people purchasing through the exchange and the
10 State of Connecticut would pay the cost of those mandates
11 that fall outside of the federal employee plan, for
12 example.

13 MR. FRAYNE: I'm just curious if, not that
14 this would happen, but if it did, if Connecticut decided
15 it wasn't going to create an exchange and it was going to
16 have a federal exchange would the mandates still apply?

17 MR. CAREY: Yes, because the -- first of
18 all, you can't -- the Department of Insurance doesn't go
19 away in 2014. They still regulate this market. And the
20 mandates still apply until the legislature decides that
21 they don't apply. The -- if the -- in those states, and
22 there will be many states that have what they're calling
23 a federally facilitated exchange, the benchmark plan will
24 be the largest small group plan. So if Connecticut

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1 didn't set up an exchange the feds supposedly would come
2 in and set up an exchange. And the Aetna POS, again,
3 supplemented by a drug benefit from here and habilitative
4 services from there would constitute the essential health
5 benefits package for Connecticut.

6 So in states, you know, I work in Alabama.
7 Alabama is not known for a lot of state mandates. So
8 their essential health benefits package will look
9 different a little bit than Connecticut's essential
10 health benefits package. But it will be based on any
11 mandate that applies in Alabama and the largest small
12 group plan in Alabama.

13 MR. FRAYNE: Just one other question in
14 terms of the principles I think these principles make
15 some sense. Are you suggesting a timeframe for the third
16 principle on minimized fiscal impact? Because I'm
17 assuming we mean over the course of the next two years
18 because it's kind of hard to predict, you know, whether
19 the federal government will actually step up and define
20 in a more robust way what the essential benefits are.

21 MR. CAREY: Yes, because this decision
22 really is, under the current scheme, a two year
23 decisions, a decision that affects 2014 and 2015. That's
24 the only thing we can go by right now. And so it really

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1 is focused on this two year period and what Connecticut
2 wants to do with regard to the essential health benefits
3 package. So, yes, I would say that it is a short term
4 issue.

5 CHAIRPERSON DOWLING: I think it might be
6 instructive just to, again, frame some of the questions
7 that I've been hearing. Mary Ellen, I'm going to ask you
8 just to inform the group about the memo of understanding
9 that the exchange has signed with the Department of
10 Insurance so everybody understands the way business is
11 regulated today, the plans are regulated today, and the
12 way they will when they're within the exchange, I think
13 that might be instructive.

14 MS. BREULT: Sure. So basically the
15 Connecticut Insurance Department is the regulatory body
16 now. We will continue to be the regulatory body. So all
17 carriers will have to be licensed by the Insurance
18 Department before they can operate in the State of
19 Connecticut. They will have to file all of their
20 policies forms for prior approval with the Department.
21 They will have to file all of their rates with us for
22 review.

23 So, all of those things are not going to
24 change. And some of those things are required to be part

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1 of the certification process for the exchange. So rather
2 than duplicate those processes and have carriers have to
3 go through a two step process when still with regard to
4 state law they still could not issue anything unless the
5 Department approved it. We have a memorandum of
6 understanding with the exchange and basically the
7 Department is just outlining all of the functions that we
8 will continue to do and the processes that we will use to
9 notify the exchange of who is licensed, what's approved,
10 verify the essential health benefits are intact,
11 etcetera. And we'll continue to do consumer -- if
12 someone complains to the Department about a company
13 obviously we will continue to pursue that and investigate
14 that. We do market conduct. We'll do the financial
15 reviews. So, hopefully that's helpful.

16 MS. FOX: Another thing I'm struggling
17 with a little bit here we're, our first task is to define
18 what is included in this essential health benefits
19 package, right. So we're just really looking at the
20 benefit structure regardless of which company provides
21 that now. But to get to the affordability issue where
22 does that come into the process in terms of looking at
23 alternatives about the funding? So, if we look at ACO's
24 or if we look at what's going on in Massachusetts now

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1 where they're making a very aggressive effort to control
2 costs where does that come in? Does that come in after we
3 structure the benefit package? How do we start getting at
4 the affordability issue from that perspective?

5 MR. CAREY: Yes, I think it follows on the
6 essential benefits package. First you have to define what
7 your benefit package looks like and then you can get into
8 things such as, you know, limited provider networks or
9 tiered networks, or, you know, medical home initiatives
10 and that sort of -- the structure of the cost sharing
11 within the plan will all factor into the question about
12 affordability. So, Massachusetts right now is very, lots
13 of small groups are moving to tiered networks or select
14 networks, which have shown to be, you know, meaningful
15 savings in premium. And so that's a way to get at this
16 issue of affordability a little bit. And they also have
17 a very, you know, aggressive Department of Insurance that
18 reviews rates and rejects rates sometimes just as the
19 Connecticut Department of Insurance reviews and rejects
20 rates sometimes.

21 MS. FOX: Okay, that's great, thank you.
22 And, you know, just so that use the premium structure now
23 as we look at that as a set of data points and not be
24 confined by what is today that was part of my reason to

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1 just kind of go down that path now.

2 MR. CAREY: Yes. I mean I think that the
3 premium issue is complicated because of the, among other
4 things, not just the benefits covered but the cost
5 sharing associated with the particular plan. Okay.

6 MR. TESSIER: Just to follow on that
7 question, so in trying to determine which of the options
8 of the benchmark plans to chose for the essential health
9 benefits package on the affordability issue so are you
10 saying then that -- you said earlier that you can't --
11 that it's apples to watermelons to compare the state
12 employee plans, the small group plans, the federal plans,
13 and I appreciate that. Are you saying also that we can't
14 -- that we can't compare them on affordability for the
15 reason you just gave that there, in fact, are probably --
16 I mean we know from the ERISA report that the small group
17 plans tend to be at a lower than bronze level in
18 actuarial value. So that goes to the issue of cost
19 sharing, right? Is that the -- is that the kind of the
20 central issue of difficulty between large plans, state
21 employees plans, small group plans, federal plans on the
22 issue of affordability is that why?

23 MR. CAREY: Yes, I would -- it's largely
24 the member cost sharing that's driving the premium

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1 difference across groups. The issue of affordability
2 plays in here I would suggest -- in fact, we had it as
3 one of the -- we were going through and put together what
4 are the decision criteria and we put affordability in
5 there and I said, well, it's not part necessarily, but in
6 this discussion I would suggest the one area where there
7 might be some issue of affordability is any limits that
8 may apply to the plan. So we'll go through that in the
9 next slide on the limits that may apply to plans and
10 difference in limits, which are still, would still be
11 allowed under the ACA. There cannot be a dollar limit,
12 but there can be a visit limit or service limit. That's
13 the issue there.

14 MS. O'GARA: I just want to give a time
15 check. You've got a lot to get through and I think we
16 have a half hour. So I just want to make sure we're all
17 mindful of that because I would hate to have you not be
18 able to complete your presentation.

19 MR. CAREY: Okay. So the first thing we
20 did is look at limits and exclusions and so, and really
21 try to identify where there are key differences in terms
22 of any limits or exclusions. Virtually all of the
23 benefits, per say, are unlimited. Meaning that if you
24 have -- if it's medically needed you're provided the

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1 service until you don't need the service in patient
2 hospitalization, or office visits, or prescription drugs
3 it's not -- there aren't sort of hard stops. In some
4 states there are some plans and some Medicaid programs do
5 have hard stops on certain things. They'll only cover 30
6 days in the hospital or whatever it may be. Or the mini-
7 med plans, you know, have a hard stop in terms of the
8 benefits offered.

9 But the plans that we looked at most of
10 the categories of care are not limited. There were four
11 areas in which there were differences, home health,
12 skilled nursing, rehabilitation benefits, and
13 chiropractic care. With regard to the exclusions there
14 are sort of generally all of the information we looked at
15 was -- there was a common themes across in terms of
16 what's excluded. And I think we sent to you the actual
17 exclusions language from each of the plans. There were
18 some differences, I don't think it's -- unless people
19 want to, I don't think we need to go through these in
20 detail. You have the packet with you. We just tried to
21 pull out some areas where it appeared that there were
22 some exclusions that were particular to a given health
23 plan.

24 Again, the feds have not made clear

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1 whether the exclusions portion of the benefit package
2 needs to be the same. They have looked at the limits and
3 they had said to look at limits when making a decision
4 about essential health benefits package. But the
5 exclusions, again, is regulated by the Department of
6 Insurance and has to fall within the requirements that
7 they put in place with regard to what a plan can exclude
8 from coverage.

9 So, here is just so I get into some of the
10 detail, you can see -- so, yes, means that it's not
11 limited. Again, it's not like you can go to your
12 doctor's office every day and the health plan will pay
13 the, will reimburse the doctor for the visit, but that
14 for medically necessary care and for certain services
15 it's not, there is no hard limit on what's provided. The
16 differences that we identified were in home health care
17 services and skilled nursing facilities. You can see it
18 varies from 30 days to 90 days to unlimited for skilled
19 nursing facility care and from 80 visits to as much as
20 200 visits per year for home health care services for the
21 state employee plan.

22 DR. MCLEAN: I'm sorry, yes, means no
23 limit?

24 MR. CAREY: Yes, means no limit, correct.

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1 We didn't identify any differences in
2 these categories. There was no hard limits on anything
3 provided.

4 And then, again, the issue here on the
5 prescription drugs is the rider issue. So Oxford PPO and
6 the federal employee plans are the only two that don't
7 offer it as a separate rider.

8 MS. JAFF: Just a really quick question,
9 on the Oxford prescription drug plan you've got the yes
10 there for both lines. So they do have a specialty tier?
11 It's not just that they cover specialty drugs, but
12 they're in a separate specialty tier that's a co-
13 insurance as opposed to co-pay?

14 MR. CAREY: Yes. And so we actually really
15 shouldn't have split them because both -- the tiering is
16 not necessarily an issue for the Committee. It's do they
17 have a prescription drug plan and does it provide
18 sufficient coverage. And I think -- so all three of them
19 should just be yes. They have, you know, a prescription
20 drug plan and it covers specialty drugs. Yes, there is a
21 specialty drug tier, but, again, some of the cost sharing
22 is not necessarily the issue.

23 DR. MCLEAN: A question, so on the basis
24 of that the EHB has to have prescription drug coverage.

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1 So does that alone make us say, no, we cannot even
2 consider those others and we're down to these three?

3 MR. CAREY: No, what that -- what that
4 does is it says for the medical plan the non-prescription
5 drug part of coverage you could pick Anthem Blue Cross
6 HMO, or Aetna HMO, or Connecticare HMO, but under current
7 guidance from the feds you'd have to supplement that with
8 either the federal employee prescription drug benefit or
9 the Oxford PPO prescription drug benefit. So you could
10 couple them in that sense.

11 DR. MCLEAN: So in this case, we can do
12 kind of a little bit of pick and choose and not in a lot
13 of the other stuff though.

14 MR. CAREY: Correct. Then on
15 rehabilitative services there were meaningful differences
16 across the plans. And as you can see it ranges from 20
17 visits for -- or 20 days in a rehabilitative facility for
18 the Aetna HMO to 90 days in Connecticare. It ranges from
19 20 to 60 with regard to PT, OT and ST. They're
20 comparable in chiropractic care and then they all, of
21 course, abide by the state mandate on autism coverage. So
22 we tried to pull out for you and identify those areas in
23 which there was a difference in these types of services
24 if there were any limits that applied.

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1 And then on the vision and pediatric
2 dental, if there is a yes in a couple of these categories
3 I will say it's probably not -- it won't satisfy the
4 requirement for comprehensive pediatric dental care that
5 will be required in 2014. So even if there is a yes for
6 Oxford PPO and Anthem Blue Cross the extent of coverage
7 will need to be supplemented I have a sneaking suspicion
8 by either the federal, a coverage that's comparable to
9 the federal plan or a coverage that's comparable to the
10 state's CHIP dental plan.

11 So, that I think brings us to a point
12 where I guess we'd open it up and we sort of have some
13 questions. Maybe I'll turn it over to Nellie.

14 MS. O'GARA: So as you -- Jennifer, I'm
15 going to call on you in a minute, but I kind of want to
16 level set this. So we have a couple of challenges. We
17 have seven plans. Some of them fit or a feasible options
18 better than others. It seems complicated, but I think we
19 might be able to simplify it. If we think about I'd like
20 to put the plan back up, the plans, if we just hold that
21 and have a general discussion about the acceptability of
22 using any of the plans. And, Jennifer, you had a comment.

23 MS. JAFF: I would like to propose that we
24 eliminate the federal employee plans for two reasons.

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1 First of all, as Bob has explained since the federal
2 employee plans don't include all of the mandates if we
3 chose a federal employee plan the State of Connecticut
4 would have to pay the cost of those mandates. So, that
5 violates the principle of minimizing the cost to the
6 state.

7 And the second reason is that the federal
8 employee plans do not cover elective abortion. They only
9 cover abortion for in cases of rape and incest and the
10 life -- threats to the life of the mother. I -- so, as I
11 understand it, if we chose a federal employee plan we
12 would be stripping elective abortion from all insurance,
13 individual and small group insurance policies that are
14 sold in the State of Connecticut starting in 2014. And
15 I'd like to think that that is not a tenable option in
16 this state.

17 MS. O'GARA: So any more discussion from
18 the group on the suggestion that with the federal
19 employee benefits? Yes.

20 MR. TESSIER: I won't waste a lot of time
21 I think for the reasons stated. It's a great way to
22 start.

23 MS. O'GARA: Is there a consensus among
24 the group that we could just begin then to focus -- yes,

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1 Steve?

2 MR. FRAYNE: I think it's also a great
3 place to start. The only caveat I would have, and I
4 don't know if you meant this or not, but I'm assuming
5 what we're talking about is for the medical piece right
6 now. We're not talking about for either dental or for the
7 pharmacy.

8 MS. JAFF: Right, exactly.

9 MR. FRAYNE: Okay. Then I would concur.

10 MS. O'GARA: So, could we take a vote,
11 show of hands to eliminate the federal employee health
12 benefit plans.

13 DR. MCLEAN: I have a quick question
14 first, so and there is no way that that termination and
15 pregnancy benefit can be kind of carved out in that way.
16 So if we like everything else about the federal plan, you
17 know, in terms of other things we can't pick and chose at
18 that level.

19 MR. CAREY: Yes, it's not an a la carte
20 menu.

21 MS. O'GARA: So, Jennifer, I don't want to
22 restate your motion, but maybe you could add the
23 clarification that Steve suggested for the medical piece.

24 MS. JAFF: Okay. So my motion is that we

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1 eliminate consideration of the federal employee health
2 benefit plans as relates to everything other than
3 prescription drugs, dental, and vision.

4 MS. O'GARA: And your reasons for that
5 being?

6 MS. JAFF: The cost to the state of having
7 to pay for mandates that are not included in the federal
8 employee plan, and the fact that the federal employee
9 plans do not cover elective abortions.

10 MS. O'GARA: And could we take a simple
11 show of hands for that. Everyone in favor, if you could
12 raise your hand. Okay, we have 100 percent behind that.

13 So, the next task then is to take a look
14 at the others.

15 DR. MCLEAN: A question first, so if we're
16 going to follow through and actually try and get an
17 estimate of what the premiums are I guess we eliminate
18 the federal plans. I mean I'd be interesting in knowing
19 while there are these other mandates, you know, if they
20 are within the federal plan, I mean, the federal plan may
21 not be any more or less. Although I agree with taking it
22 off the table for the reasons you stated, but I don't
23 know that the price would necessarily be different. I
24 have no idea without seeing it. Do you have a sense of

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1 that?

2 MR. CAREY: Yes. The federal plan actually
3 has -- I mean it's very comprehensive, but there is not
4 insignificant member cost sharing at the point of
5 service. So, I've done a considerable amount of work
6 looking at municipal plans and state plans and compared
7 those to federal plans and private sector plans, and the
8 federal plan looks a lot like a typical private sector
9 employer plan. It's not -- I think the cost sharing,
10 you'll see, is not insignificant in the federal employee
11 plan. So, I have a sneaking suspicion that it's probably
12 less expensive than the state employee plan, but I also
13 have a sneaking suspicion that's due almost 100 percent
14 to the amount of point of service cost sharing in the
15 federal plan vis a vie the state employee plan. And so
16 that's going to drive the delta not so much the
17 additional benefits that might be covered under the state
18 employee plan.

19 DR. MCLEAN: Meaning in the federal plan
20 they are paying, the patient is paying more.

21 MR. CAREY: Correct.

22 DR. MCLEAN: Okay.

23 MS. O'GARA: So another way to look at the
24 remaining options, we had suggested, and I think you

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1 agreed with three criteria, one being comprehensiveness
2 and they're all pretty comprehensive, and the second
3 being -- let me check my notes -- aligning with the
4 current Connecticut marketplace. And one indication of
5 that is that all of these that are left are fairly large
6 enrolled products in the marketplace.

7 MR. CAREY: Yes, I guess the one way that
8 you might think about distinguishing that is that because
9 the EHB applies to the individual and small group market
10 should a criteria be that we want to align more closely
11 to products sold in the individual and small group
12 market, which would then lead one to perhaps eliminate
13 the state employee plan as an option. I just sort of
14 throw that out there for consideration.

15 MS. O'GARA: Yes, Bob.

16 MR. TESSIER: I've been kind of thinking
17 about and trying to weigh the merits of the -- I mean it
18 seems to me that the state employee plans are three of
19 the ten benchmark plans established by HHS for us to
20 consider. So, on that basis to kind of exclude them
21 doesn't seem to me to make a lot of sense. And I guess
22 the other -- and it's part of why I was interested in the
23 volumes, the enrolled volumes of all of the plans to get
24 a better sense of kind of how much of the Connecticut

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1 marketplace does each of these plans represent. And I
2 guess I mean I think that, just my opinion for what it's
3 worth, I think you're -- it's a good question you're
4 asking, Bob. I'm sorry, Nellie, it's a good question
5 you're asking. And there is a certain logic to it or a
6 good reason to it. I guess I'm trying to -- can anybody,
7 maybe can you, Bob, speak to the issue of how would you
8 distinguish between, generally between the state plans
9 and the small group market plans. My impression is that
10 it's, again, the issue of cost sharing. And I think you
11 said in the beginning that's really not part of the
12 exercise today.

13 MR. CAREY: I guess it's a distinction
14 aside from cost sharing are any limits that might be
15 placed on certain services for which there are typically
16 limits placed. You'll see on rehab, PT and OT there is a
17 pretty, you know, big distinction between unlimited
18 coverage and the limits that are placed in the small
19 group market on some of those types of services. So
20 those are really, you know, you're sort of getting down
21 to a very much a line item consideration of which one
22 should be the benchmark plan. So those -- that perhaps
23 is the only area I would suggest where there is a
24 distinction between the state employee benefit and the

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1 benefit offered in the individual and small group market
2 or the small group market in this instance.

3 MS. O'GARA: So would it be fair to say,
4 and we're only looking at what we have here, that in
5 general the state plan has fewer or higher limits, in
6 some cases unlimited for some of these, could you then
7 make the connection that if we selected that if we
8 selected that it could end up being the most expensive?

9 MR. CAREY: Yes, I would say that it
10 would have an effect on the premium if you go from a 20
11 visit limit to unlimited. Again, this is a benefit. It's
12 not like hospital stays or doctor's visits in general.
13 It's, you know, there certainly is a percentage of the
14 enrolled population that will need rehabilitative
15 services. How many of those -- I guess the issue is how
16 many of those people need 22 and are only getting 20
17 today or they would have received 50, but they were only
18 -- but they're limited, the plan limits them to 20. So it
19 gets down to I think small numbers, but it's not -- the
20 point is that that's -- these are the products that are
21 sold in the market today. We have to remember that we're
22 going to be making a recommendation that will then have
23 an effect on products sold in the market in 2014.

24 DR. MCLEAN: A question, so especially

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1 being a rheumatologist and dealing with a lot of physical
2 therapy referral and a lot of these issues, the question
3 I have is when there are limits are those limits per kind
4 of episode, diagnosis or limits for the calendar year for
5 anything?

6 MR. CAREY: Yes, it's typically limited to
7 a particular condition or an accident or something that
8 occurs.

9 DR. MCLEAN: Which, quite frankly, makes
10 it much more reasonable. I mean if somebody had two
11 injuries in a year and they each needed 20 visits I think
12 it would be unfair for them to be cut off at the knees,
13 literally, at 20 visits if they had a different diagnosis
14 or problem. So I mean I think that is okay if those are
15 episodes or diagnosis based and not limits for the year.

16 MR. CAREY: I believe that they are
17 episode based, that they are not, sort of, a fixed
18 calendar year or a planned year limit, but we can --
19 we'll double check that.

20 MR. FRAYNE: Maybe the flipside of the
21 concern that or the issue that Bob was raising and a
22 concern that I have is as while I think in the short run
23 for the next two years perhaps actually going in the
24 direction of the state employee's plan because it would

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1 have more coverage or less limitations might be a good
2 thing when we get past those two years it could be a bad
3 thing. And what I mean by that is at some point the
4 federal government is going to step in and they've kind
5 of kicked the can down the road for at least the next two
6 years to say, well, we're not going to really decide what
7 the limitations are. And my guess is if you compare
8 Connecticut to most other parts of the country whether
9 we're the small group market or the state employees
10 probably our benefit package is significantly richer than
11 other places. So, I wonder whether we're setting
12 ourselves up for a rather disappointing event when we hit
13 2016 when the federal government begins to step back from
14 allowing this flexibility and saying to the State of
15 Connecticut, well, you're more than welcome to cover all
16 of those things, but now it's an issue for the state
17 budget, which while getting better isn't at a place yet
18 where everyone feels like they can spend whatever money
19 they feel like.

20 So, I just think we have to -- we can't
21 simply think about what's going to be the best for right
22 now, but try to at least anticipate where we think we
23 might be after this two year period is up.

24 CHAIRPERSON DOWLING: I would agree and

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1 I'm concerned for the same reasons that suddenly we set
2 ourselves up for a very political and emotional take away
3 negotiation. And also if we do have a tenet of
4 affordability we do have to be mindful of that that if we
5 are selecting the richest because everybody emotionally
6 wants that we're also setting ourselves for two years
7 from now tax issues, fiscal issues, trade off issues,
8 ugly conversations. And if we're going to be put on the
9 hook in 2016 I think those conversations are going to
10 happen anyway because suddenly it will be a state rather
11 than a federal conversation, but I'd rather minimize
12 those and say, let's talk about adding two more visits or
13 let's talk about this rather than saying let's take away
14 something that was unlimited and start negotiating.

15 So, I just for purposes of process might
16 propose a vote or a discussion on whether we can
17 eliminate the state plan for some of the reasons stated
18 just to continue our winnowing. Just to see where we
19 are, maybe a straw vote.

20 MS. O'GARA: Bob.

21 MR. TESSIER: I'm wondering if I could ask
22 Bob one more piece of -- do we have any data on have
23 other states made any of these decisions, elections, the
24 essential health benefit package decision and do we know

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1 anything about the decision, this issue?

2 MR. CAREY: I don't think any state has
3 made a formal decision on their essential health benefits
4 package. They're sort of going through the same thing
5 that we're going through right now. I can say that the
6 general conversations that I've had with colleagues and
7 with that are working in those states and just my
8 involvement in those states is that it generally comes
9 down to sort of get rid of the federal employee plan,
10 we're not going to go that option. That's sort of the
11 easier of the decision.

12 And in some states they are more focused
13 on the small group plans because they feel that that's
14 currently in the marketplace today and we should be as
15 close to the market as possible. And while other states
16 are taking a more nuanced approach and also considering
17 the state employee plan, but I will say it sort of breaks
18 down along that line between the feds sort of get taken
19 off the table pretty quickly because they're just looking
20 at their own state plans.

21 DR. MCLEAN: A question.

22 MR. CAREY: Yes.

23 DR. MCLEAN: I was going to say that I
24 know that I think the only other state that has more

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1 mandates than Connecticut is Rhode Island. So I was just
2 wondering if you had any insight into what their thinking
3 is in terms of some of this because I think the mandates
4 are a big issue for us which we can't avoid.

5 MR. CAREY: Well, as a native Rhode
6 Islander, they're looking at their state plans. They're
7 putting off the federal plans for the time being. So I
8 don't -- I think that's the approach that they're taking.
9 I don't think there is any appetite, to be honest, in the
10 legislature to undue the mandates and there is -- given
11 that at least two cities are on the verge of bankruptcy
12 in Rhode Island there is no money in the state treasury
13 to pay for the mandates if they did go for the federal
14 plans. So that sort of -- that one issue alone just
15 almost takes it off the table immediately for states once
16 they get their head around that fact.

17 MS. HARDICK: I was just going to make one
18 statement regarding looking at the visits and the
19 differences, and I just wanted to generally say I think
20 plans when they go to build these packages and their
21 benefits they look at a lot of data, utilization,
22 clinical outcomes to determine what -- how many visits
23 they should offer in a plan. So I think maybe there is a
24 reason for that. And I don't think they would be offering

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1 unlimited or if -- I mean I think they would be limiting
2 it if they find that it's reasonable. It's been medically
3 sufficient based on utilization that they've seen. I
4 just wanted to state that.

5 MS. O'GARA: Jennifer, and then I'm going
6 to see if we can take a straw vote on the suggestion.

7 MS. JAFF: I have one comment and one
8 question. I feel -- it's very important, obviously, to
9 have affordability. There is no argument there. However,
10 it's hard for me, as somebody who represents consumers,
11 not to be particularly attracted to plans that have
12 higher or no limits on coverage. And so I don't know that
13 -- I don't know that I'm at a point where I know enough
14 about the difference in cost to be able to weigh that so
15 that the cost outweighs the addition to the benefit
16 package.

17 I do have a question though. And that is
18 am I missing anything on the -- if we -- I understand if
19 we chose the Oxford PPO that includes the prescription
20 drug plan. And that's kind of nice for ease of
21 administration, I suppose. Is there any other plus or
22 minus to having the -- to choosing Oxford with a
23 prescription drug plan?

24 MR. CAREY: I think that the requirements

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1 that will come down on the formulary requirements that
2 the feds will put in place will be really what's most
3 important with regard to the prescription drug plan. I
4 think other than a generics only plan, for example, that
5 -- and there are some carriers that offer just a generic
6 drug benefit, most of these formulators are comparable in
7 terms of what's covered. The issue is always what's the
8 cost to the member. Right? So you can buy a drug
9 benefit with co-insurance, you know, 50 percent co-
10 insurance. They're in the market today for tier three
11 drugs. Or you could have a 50 dollar co-pay. The
12 formulary doesn't change it's really just the cost
13 sharing that changes. Although there are some more
14 restrictive formularies out there in the marketplace,
15 generics only or very closed tight formulary.

16 DR. MCLEAN: I hadn't thought about this,
17 so I mean Oxford is a bad word in the medical community
18 because they don't pay enough and their formularies are
19 horrible. And because they don't pay enough their
20 networks are horrible. So you can't get people referred
21 to specialists. I mean that's just plain. So, while I
22 guess I want to kind of get my hands around the process
23 if we pick the Oxford one it doesn't mean that we are
24 picking the specific Oxford formulary, it's the premise

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1 of how their formulary is. So whatever this design is is
2 then going to be thrown out there and every insurer in
3 the state can say, if I'm going to put together that
4 exact package this will be the cost. Correct?

5 MR. CAREY: Correct.

6 DR. MCLEAN: Okay.

7 MR. CAREY: And the formulary is going to
8 change in 2014 so you can't take a snapshot in time and
9 say, this is the formulary. And there will be guidance
10 from the feds that won't allow a very, very restricted
11 formulary, so we can expect that to be -- that will have
12 to be part of the package that we -- then go to the
13 market and say, this is the benefits package for
14 Connecticut.

15 MS. O'GARA: I would like to ask a
16 question about you had an interesting notion there,
17 Jennifer, if we look at Oxford just as one example, is
18 there anything in the limitations that raises people's
19 concerns significantly as you compare it to some of the
20 others?

21 MR. TESSIER: I just want to make an
22 observation and I'm not a medical person or a clinician
23 of any kind. I want to make that clear. But it seems to
24 me, Jennifer made the observation that we're looking at

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1 this without having any real sense of the cost
2 differentials. And it occurs to me that we're looking at
3 when you consider all of the essential benefits we're
4 appropriately looking at some distinguishing features
5 between the plans, but we're really looking on the
6 margins, at this point, and we have no idea what the
7 numbers are. And I want to make another comment. It seems
8 to me it's a kind of a two dimensional look at the plans
9 and there is, you know, a very critical factor here and a
10 distinguishing feature between carriers and that is care
11 management. And frankly care management can take a plan
12 that has no limits of any kind on coverages and make it
13 work better and be cheaper for the consumer and for the
14 carrier than a plan that has other, has limits. I mean
15 they just can if it's really effective care management,
16 and it's consumer orientated and they're working with the
17 patient, and working, as Mary referred to earlier, on the
18 provider reimbursement side if the carrier is also doing
19 some innovate things there is all kinds of ways to save
20 the real money in the system and not making the
21 distinction based on limitations on the margins.

22 MS. JAFF: And if I could add to that, I
23 think that's so right and as someone who does a lot of
24 insurance appeals these coverage limits are somewhat

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1 illusory because you don't necessarily get 60 physical
2 therapy visits from Oxford you get a number of visits
3 that are -- that Oxford decides is medically necessary
4 that will be maxed out at 60. But you may only get ten.
5 So it really -- I think Bob's point is very right that
6 how prior authorizations and care management is
7 administered probably makes more of a difference than any
8 of these coverage limits on paper.

9 DR. MCLEAN: A question, so part of the
10 stuff though does not include how they define care
11 management and some of those issues though, correct?

12 MR. CAREY: Correct. That's right. So any
13 prior authorization, or step therapy programs, or
14 determinations of medical necessity that's not part of
15 this discussion.

16 DR. MCLEAN: And is there at any point
17 where the state or the insurance exchange can state
18 expectations within those arenas?

19 MR. CAREY: Sure. The Department of
20 Insurance does today have certain expectations in those
21 arenas. Plans can't arbitrarily cut people off from
22 medical necessary services and there is a whole, as
23 Jennifer knows well, a whole process involved in that.
24 But from the exchange's perspective the exchange for its

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1 plan, the plans that it will offer could, you know, state
2 its preferences for certain types of plan designs or
3 certain types of medical management practices. Or, you
4 know, when we put together the initial offering in
5 Massachusetts for the connector we promoted tier
6 networks. We think that's a way in which you can engage
7 the consumer. You can drive down price and you can
8 reward, you know, most efficient, high quality providers
9 that was the option we took. But so all of those types of
10 decisions will be largely exchanged, focused decisions.

11 The Department has certain
12 responsibilities and oversight of all carriers, but in
13 terms of any type of plan preferences that would be this
14 Committee's work, you know, down the road will be part of
15 that discussion. How do we structure the solicitation
16 document that we're going to put out into the market to
17 get the plans on the shelf for the exchange.

18 DR. MCLEAN: So I guess I would -- I mean
19 I agree with what was stated before that I mean I have
20 concerns that when you have a limit, you know, somebody
21 is going to play with that limit and even shrink it
22 further. So having it unlimited gives you a comfort level
23 in terms of some of these benefits which I agree with. At
24 the same time, speaking as a clinician, you know a lot of

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1 these things do not need unlimited coverage. And if you
2 make it unlimited the patient or the provider will find
3 ways to make it unlimited. And that is a huge expense.
4 And so I think having limits is completely reasonable as
5 long as those limits are reasonable like episodes and
6 it's not calendar for the year. So, I think as long as
7 it's crafted after this decision in the right way I think
8 it will be more affordable clearly.

9 And while affordability is one of our
10 priorities that's really not the priority, it's providing
11 adequate coverage. So, if the group decides that, yes, 60
12 visits per episode is pretty reasonable coverage for a
13 given PT need then that's really kind of a decision now,
14 the cost we kind of can't really control.

15 MS. O'GARA: So, may I make an
16 observation? What I'm beginning to hear is that there is
17 probably one of these four small group products that's a
18 feasible option. I'm not going to suggest the one. And
19 we're not at the point where we're ready to eliminate the
20 state plan. So if we leave the state plan in for talking
21 purposes, even though we all recognize fiscal impact and
22 affordability, and we look at the other four is there
23 some attractiveness to the Oxford PPO as being one of the
24 most feasible of the other four. And I ask that because

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1 of the riders in there. I ask that because in looking
2 across the limitations they aren't extremely limited, not
3 knowing anything about their care management program.
4 They're not necessarily middle of the road either. They
5 have some pretty good opportunities.

6 So, when you weigh the balances and just
7 trying to drive us to maybe focusing in on a couple of
8 options does that make any sense to you to leave the
9 state in for now and say of the other four we have a
10 preference among the four?

11 MR. CAREY: I would only just suggest that
12 a "to do" for the staff is to better explain what the
13 limits are for each of the carrier plans. So, we want to
14 make sure that the 30 visit limit is per episode not per
15 year, for example. So, a take away for us will be to come
16 back with you with the details of these distinctions.

17 MS. O'GARA: And we also have to get the
18 enrollment. Bob, you had asked for the enrollment across
19 the plans. I'm still struggling with the idea of getting
20 a premium just because of all of the variables that go
21 into setting a premium. And, Steve?

22 MR. FRAYNE: I'll make a suggestion then
23 and people can either go with it or not. I would,
24 different than I think what you were suggesting, Nellie,

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1 I would not suggest picking the Oxford PPO because of the
2 rider issues. Instead I would recommend that if we want
3 to winnow this down further that we leave the state
4 employee plan in, since I think, you know, we're of two
5 minds, at least at the moment, about whether it's a good
6 thing or not a good thing.

7 And then I would winnow it down to the two
8 largest remaining plans. It seems to me, which I think
9 is Connecticare and Aetna point of service plan, it seems
10 to me those are the two plans which have the largest
11 presence currently in the marketplace. There has to be a
12 reason for that. It must be that it balances
13 affordability, and appropriate access, and coverage
14 because I would think that if it didn't balance all of
15 those particular things they wouldn't really be able to
16 sell their products in the marketplace. So I would go
17 with keeping the state employee plan and then, for the
18 moment at least, going down to the Aetna point of
19 service, which I think is the largest small group, if I'm
20 correct, and the Connecticare HMO, which is the largest
21 in the HMO or larger group market as a place to start.
22 Then at least we'd be down to three plans to consider.

23 I wouldn't pick Oxford simply because of
24 the rider issues. I think they have a much smaller

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1 presence than the other two plans in the state. I'm not
2 sure why that is, but they do or have had a much smaller
3 presence.

4 MS. O'GARA: And so you'd deal with the
5 prescription issue separately.

6 MR. FRAYNE: I would deal with the
7 prescription rider issue as well as dental and vision as
8 separate questions, yes.

9 MS. O'GARA: What about some discussion on
10 that?

11 CHAIRPERSON DOWLING: I like that idea
12 because I think it balances. I'm worried about taking two
13 plans that are the richest and then determining between
14 those because I am still very concerned about one of the
15 three tenets, which is affordability and this is only one
16 of the issues that's going to impact the choice of
17 benefits, affordability. We also have rate compression
18 coming, we have changes in whose is covered, pre-existing
19 conditions, all these types of things that build up. And
20 so while we may feel that we have achieved a victory by
21 having the most comprehensive and unlimited set of plans,
22 we're setting ourselves up for then having nobody being
23 able to be afford it because overall we've seen the MERSA
24 plan, report telling us how many fall below the lowest

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1 medical plan in terms of actuarial value.

2 So, I just want to be careful that we
3 balance both sides of any kind of accounting and I say
4 this because there is no other committee out there that's
5 looking at the financial balance. We're it, so, until we
6 look at a financial subcommittee of the board.

7 So, I also say we're going to get the
8 enrollment data. We may get base premium data. I guess
9 I'd like to ask the Committee what we're going to do with
10 that because at the end of the day, you know, it's a
11 question of affordability as well as comprehensiveness.
12 And I think your subtle distinction of what these
13 limitations mean per episode, and we're hearing from some
14 practitioners that they seem healthy, we're hearing from
15 a carrier that they are done very thoughtfully, but I
16 agree with you also, Bob and Jennifer, that perhaps we
17 don't know that it's such a small distinction. But when
18 anything is unlimited I don't think that's always on the
19 margin.

20 So, I guess what I'm concluding to suggest
21 is supporting this proposal that perhaps we have. The two
22 that have some range, looking at their 20 days, 90 days,
23 20, 40 versus taking the unlimited and then the 60. I
24 would be comfortable with that, but I also want to make

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1 sure that we don't keep analyzing without coming to a
2 conclusion. Once we get the data that's been asked for
3 what are we going to do with it. Are we going to make a
4 distinction because it's got 50 more people than somebody
5 else or -- and that's what I worry about. What are we
6 going to do with that data?

7 MS. O'GARA: Any other comments?

8 DR. MCLEAN: So you like the Connecticare
9 HMO because it had 90 as opposed to 60 being maybe even
10 too much of a limit in terms of looking at the table.

11 CHAIRPERSON DOWLING: What I was saying is
12 if people aren't ready to give up yet and at least those
13 two give us a wide range of the commercially available
14 plans, and we'll do something with that.

15 DR. MCLEAN: I don't know if it makes a
16 difference with Oxford having already -- even though it's
17 called a rider that has a prescription drug benefit so
18 Steve was kind of implying that that seemed to be a
19 problem, but you kind of implied that wasn't, that it was
20 called a rider versus not a rider. And I think -- I mean
21 I would be hesitant to necessarily -- and believe me I
22 have no preference for Oxford as a name, as I said, but I
23 wouldn't want to write that off without really knowing
24 the distinction between the yearly versus the episode as

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1 far as the limits, in all honesty, because I don't know
2 what 60 or 90 means yet.

3 MS. O'GARA: But I think this prescription
4 thing -- you want to comment on that, Steve?

5 MR. FRAYNE: I wasn't suggesting that you
6 wouldn't consider it because of it being included or the
7 rider versus non-rider issue. What I was suggesting is,
8 I think, Nellie was putting forward a rationale that said
9 maybe we should focus on that because you don't have to
10 deal with the rider issue. And I was suggesting I didn't
11 think that was necessarily the most appropriate decision.
12 I would look at more market presence, who are the largest
13 plans currently, and I think there is some real meaning
14 to that in terms of the fact that they are able to sell I
15 this market. They're able to operate. And in order to do
16 that they have to strike a balance.

17 DR. MCLEAN: At the same time, I would
18 make the argument that Oxford has an extremely limited
19 network. I think one of the reasons it may not have a
20 presence is not because of the product, but because of
21 the downstream stuff. And I think that patients have
22 given feedback to their employers about that, I think,
23 I'm not sure.

24 MS. BREault: And if I could just put into

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1 perspective, we did ask for the enrollment data on this
2 survey that we did. The Aetna plan, which is the largest
3 plan, they reported 11,000 members roughly. I don't have
4 the exact number off the top of my head. But just to kind
5 of give you a perspective of the level of numbers that
6 we're talking about.

7 MR. CAREY: The other issue, so the
8 enrollment -- the reason that we have these three as the
9 largest is because the feds told us these were the three
10 largest. Now, you know, there has been questions about
11 the federal data. But we will be able to get from the
12 feds the numbers that they put into each of these -- the
13 enrollment numbers that they used to drive these three as
14 the largest.

15 CHAIRPERSON ESPINOSA: Bob, let me just --
16 I have to leave. I apologize. I came across some
17 information. You're talking on some of what I was just
18 going to ask. I'm not going to try to put you on the
19 spot for a response, but I just thought I'd share it with
20 the group as well. It concerns me because you mentioned
21 earlier when we first started about the conference you
22 had attended, that was a three day conference. I came
23 across this information. I'll just read it very quickly.
24 It says states that wish to operate their exchanges and

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1 work with the HHS on a partnership exchange need to
2 declare themselves and submit detailed documentation on
3 their plans by November 16 of this year. They came up
4 with that date.

5 Beside that, so my question is this one,
6 interestingly even the states that seem to be well on
7 their way to operating their own state based exchange
8 were strongly encouraged to pursue a dual track and apply
9 for partnership exchange as well as attempt to be
10 certified as a stand alone exchange. This tells us the
11 HHS doesn't believe some of the states that have started
12 their own exchanges will make the cut. And my question is
13 making the cut and not making the cut, and what does the
14 federal government envision and it is a defacto -- is it
15 going to be by default if the state doesn't make the cut?

16 And then it gets into this issue on data
17 that you were just taking about. I thought that was
18 interesting. It says states were also told a key aspect
19 of all exchanges, state, federal, and partnership that
20 has to be provided by HHS isn't quite ready yet. The data
21 hub, where all the information needed to enroll people in
22 exchange based plans, public programs, and tax credits as
23 well as verify whether or not people meet the terms of
24 the laws individual mandate is still missing some key

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1 pieces. HHS still doesn't have agreements from all the
2 federal agencies it needs to collect data from like
3 Homeland Security, IRS. It's a pretty negative report
4 that I came across. I wish I didn't, but I did.

5 So, my question on one thing is this issue
6 of not making the cut. And then that November 16th date
7 is that something that you had -- you were told?

8 MR. CAREY: Yes. So, under the law the
9 Secretary of Health and Human Services is required to
10 determine by January 1 of 2013 whether a state is making
11 sufficient progress so that it can stand up and exchange,
12 so that it can begin to enroll people by October of 2013.
13 So in January, by January we'll apply. All of the states
14 will apply or let the feds know what their plans are with
15 regard to whether they are going to be a state based
16 exchange and totally operate the exchange on their own.

17 Another option is what they're calling a
18 partnership model. So states could do some things and the
19 feds would do other things. And so those some things
20 they've limited to plan management so things like this,
21 like what's the essential health benefits package look
22 like. And what do the plans look like. States could do
23 that and they could also do consumer assistance, and then
24 partner with the feds who handle everything else. So,

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1 eligibility, and enrollment, and premium billing, and all
2 of that other stuff that an exchange has to do the feds
3 will do that. So that's sort of option two.

4 And the third option is the feds run the
5 whole thing. They select the plans. They do the consumer
6 assistance and they operate the exchange.

7 So that November 16th deadline is the
8 state needs to submit either a letter saying good luck,
9 run our exchange for us. Or they need to submit an
10 application that the feds will then review and determine
11 whether to approve the state as a state based exchange or
12 to conditionally approve the state, but something need to
13 be decided pursuant to the law by January of 2013 with
14 regard to whether a state is going to operate its
15 exchange or not.

16 That's what - the point about the federal
17 data service hub is that the feds are -- the plan is for
18 the feds to establish sort of one pipe through -- and the
19 states will connect to to determine eligibility. And
20 because the eligibility involves Homeland Security, and
21 IRS, and Health and Human Services, and Social Security
22 Administration instead of states having to connect with
23 each one of those entities individually the states will
24 connect to what they're calling this federal data

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1 services hub which would then go out into their various
2 and sundry federal agencies to pull informant on
3 enrollees. So that's what they -- that's what that was
4 referring to. And, yes, I mean there is still -- again,
5 there is a lot of work to be done at the federal level
6 not only on rules and regulations, but just sort of
7 setting up the whole system.

8 MS. O'GARA: But in terms of our job here
9 to hone in on the essential health benefits plan it
10 sounds like even under those scenarios two of the three
11 we still have that responsibility.

12 MR. CAREY: Yes, they still are deferring,
13 as much as possible, to the states to make those
14 decisions. And that decision is not a November decision.
15 That decision is a third quarter of 2012 decision. So
16 the feds are going to be expecting, and they'll let us
17 know how we're supposed to let them know what our
18 essential health benefits package looks like in by the
19 end of the third quarter or during the third quarter of
20 2012.

21 CHAIRPERSON DOWLING: It was all -- I'm
22 concerned that we're at 12:15 and we need to figure out
23 what we want to conclude today and what we want to do
24 next, and then still open for public comment by 12:30.

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1 So, I guess I'd just like to ask the Committee, we are
2 going to need to have an interim meeting between now and
3 July 11th clearly, at least one. I would just like to
4 ask you whether you would like to take this straw vote
5 now or whether -- of any kind, whatever permutation it
6 is, or whether you want to just come up with a list of
7 data that we get. It sounds like some of this data is a
8 couple of day's worth. It's not heavy duty like our last
9 request. How would you like to proceed and I'll just give
10 it to you again, a straw vote or data at a very soon to
11 follow this next meeting?

12 CHAIRPERSON ESPINOSA: I'm going to say,
13 no to the straw vote only because I don't think it really
14 is going to influence anything in my opinion, humble
15 opinion, and I have to leave. Thank you very much and
16 I'll hear from you.

17 MR. TESSIER: I would say the same. I'd
18 rather a little bit more information and I guess -- and
19 I'm not prepared today to eliminate any others that are
20 there. I don't disagree. I'm also with the Commissioner
21 with the comments you made about affordability. I just
22 don't think that we've evaluated affordability. We have
23 kind of gut feelings about the "richness" of the state
24 plan, etcetera, but I would like the volume numbers, on

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1 the enrollment numbers, if as Mary Ellen said the largest
2 small group product only has 11,000 people enrolled in it
3 that doesn't seem like a good enough basis to eliminate
4 the other two small group products unless they have
5 almost nobody in them. And I'm guessing that those
6 carriers wouldn't be offering the plans if there is
7 nothing in them.

8 And I also thought that -- a last quick
9 comment, I also thought that a lot of the discussion of
10 Oxford and all the rest, Dr. McClain and some of the
11 comments about -- I mean to me those are, I'm sure,
12 you're all right the things you said, but we're not
13 talking about picking an Oxford product, or this product,
14 or that product. We're talking about a plan of benefits
15 which would then become the basis for all carriers, small
16 group products, individual products, and exchange
17 products. So to me that's all kind of secondary or
18 irrelevant.

19 DR. MCLEAN: If I can just respond, you're
20 absolutely right and I just wanted to clarify that as I
21 see there are problems with Oxford and their numbers in
22 the state may not be that high for issues unrelated to
23 the benefits. And I just wanted to clarify that. So, for
24 example, I don't know that the numbers -- if Oxford's are

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1 low it's because I think of other reasons, not because of
2 the benefits.

3 MS. JAFF: If I could just quickly say one
4 other -- I just really quickly went through some of the -
5 - a couple of the benefit summaries and it looks to me
6 like for Oxford and Connecticare the visit limits are per
7 year, not per condition. So, I think that's really --
8 you know, before we decide which set of limits we're
9 willing to live with, I think that's a really important
10 question whether it's going to be per year or per
11 condition.

12 MR. KEVIN GALVIN: Thank you. Kevin
13 Galvin. It would be my preference to get some more
14 information and wait for -- and have an interim meeting.

15 CHAIRPERSON DOWLING: So it sounds like no
16 on the vote and the data we need then is enrollment,
17 detail on those that are limited benefits, and I don't
18 know if there is any relevance to a base premium. I just
19 don't know because there is so much mix and match to that
20 whether that's going to be informative or distracting.
21 So, was there another data element? Yes.

22 MR. TESSIER: Yes, I tend to agree with
23 you probably about that. I wanted to ask Mary Ellen, I
24 assume you probably know this, when you go back to the

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1 previous slide that had the different -- that one, thank
2 you, the different limits does the Department of
3 Insurance have the ability and without it being a big
4 deal to quantify the -- do we know the cost differences
5 in those things from carrier to carrier?

6 MS. BREault: No, we wouldn't really have
7 the capacity to do that easily.

8 MR. TESSIER: Thank you.

9 MS. BREault: I mean we would have to pull
10 the carriers.

11 CHAIRPERSON DOWLING: So it sounds like
12 we'll need to schedule something. We'll get together to
13 do something very soon with this data. And if you have
14 it, obviously, email is terrific for everybody. I just
15 want to say one thing before we, perhaps, go to public
16 comment. I just want to thank the staff again for -- and
17 consultants for everything that was done and prepared for
18 us as others have said. And I also want to thank all of
19 you for plowing through it and for -- I mean that's huge
20 work. And for being on the Committee because it's a
21 business-like decision, but it's also, you know,
22 everybody who is here is here because they have a
23 personal passion for it. And I just am very proud of the
24 way the Committee has conducted itself because we may

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1 come at this from different perspectives, but I just want
2 to acknowledge the way this Committee is working. And
3 thank you all very, very much for that.

4 MS. O'GARA: Okay, if there is no further
5 business, then we can look for a motion to adjourn.

6 Oh, I guess we have to have public
7 comment. Yes. Is there anyone in the audience who would
8 like to come forward and make a comment? Okay, we see no
9 one coming forward.

10 So then I will ask you if you could
11 entertain a motion to adjourn.

12 CHAIRPERSON DOWLING: May I hear a motion
13 to adjourn? And a second? All in favor?

14 ALL VOICES: Aye.

15 CHAIRPERSON DOWLING: Any opposed? Thank
16 you. We're adjourned.

17 (Whereupon, the meeting was adjourned at
18 12:21 p.m.)

19